For Official Use Only
Intake Staff_____
ACTS #_____

Comprehensive & Extended Care Facilities
Self-Report Form

Today's Date	**Facility Name**			**Provider #**	
Address	**City**	**State**	**Zip**	**Telephone**	**Ext.**
Name of person completing report	**Title or Relationship to Resident**			**Direct Number**	
Name of resident(s) involved					
Type of Report	☐ Abuse	☐ Neglect	☐ Injury of unknown origin	☐ Misappropriation of resident property	
Date/Time Of Incident	**Location of Incident**	**Witness(s)**		**Status of Resident**	
Alleged Perpetrator(s) (if applicable, provide license #)					

Events Of Incident(S)

Measures taken to prevent further incidents of similar nature

Results of investigation

Forward First Report Within 24 hours. Investigation results within 5 days
To Fax 410.402.8234 or email to: nhselfreport@dhmh.state.md.us